



South Dakota Board of Nursing  
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115  
(605) 362-2760 ♦ Fax: 362-2768 ♦ [www.state.sd.us/doh/nursing](http://www.state.sd.us/doh/nursing)

### Process for initial registration as a Medication Aide:

1. Beginning May 1<sup>st</sup>, 2015, currently practicing medication aides will be **grandfathered** onto the registry. You must complete and submit the Board of Nursing's Application for Initial Medication Aide Registration. Incomplete applications will not be processed. Upon receipt and review of the completed application, the Board of Nursing will place you onto the registry and send you a card. If you are grandfathered onto the registry, you will not be required to take the Board approved medication aide exam.
2. Beginning end of 2015 or beginning of 2016 all newly trained medication aides will be required to take the Board approved medication aide exam in order to be placed on the registry. It will be **required** that licensed nurses delegate only to those medication aides who are active on the registry.
3. For those not grandfathered onto the registry, upon passing the exam the Board of Nursing will list you as registered on the Medication Aide registry. Renewal of registration for ALL medication aides is required every 2 years.
  - If an applicant does not pass the exam they may retake the exam one time.
  - If an applicant does not pass the exam on the second attempt, training must be repeated in its' entirety.
4. Upon placement on the medication aide registry, the registrant must maintain current contact information (address, phone, email) with the BON.



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### Medication Aide: Initial Registration

If any of the information is incorrect, incomplete or illegible, processing may be delayed. An applicant will be notified if additional information is required. **Mail, fax, or email this completed application to the address or fax number listed above; or scan and email to [winora.robles@state.sd.us](mailto:winora.robles@state.sd.us). Allow 5-7 business for processing, then go to [www.sduap.org/verify](http://www.sduap.org/verify) to verify your application status with option to print registration card.**

*Please Print*

**Name:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Other names previously used: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street/PO Box

**Telephone:** Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_

**Email:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Gender:** ☐ Male ☐ Female

**Ethnicity:** ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

**1. Provide high school education information (or GED Equivalency information).**

Name of High School (or Equivalent)	Location of School (City, State)	Year Diploma Received (or Equivalency)

**2. Provide training verification.**

I, [Click here to enter text](#), RN verify that [Click here to enter text](#) (Medication Aide Applicant) has completed a SD Board of Nursing approved 20 hour Medication Aide Training Course. I further verify that this individual is capable of performing all the skills listed on the Board of Nursing's approved Skills Competency Checklist safely and competently.

RN signature: \_\_\_\_\_ RN License # \_\_\_\_\_ Date: \_\_\_\_\_

**3. Do you currently owe child support arrearages in the sum of \$1,000 or more?** ☐ YES ☐ NO

I, the undersigned, declare and affirm under the penalties of perjury that this application for registration in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

\_\_\_\_\_  
Medication Aide Applicant Signature

\_\_\_\_\_  
Date